

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 12506 350

**12511 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>902 Second Street</b>		d. STREET ADDRESS <b>Walnut Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>LENA</b>		First <b>P.</b>		Middle <b>BARNES</b>		4. DATE OF DEATH <b>November 15, 1957</b>		Month <b>November</b>		Day <b>15</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1901</b>		9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Alonzo G. Payne</b>		14. MOTHER'S MAIDEN NAME <b>Effie Townsend</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-5139</b>		17. INFORMANT <b>Leonard D. Barnes, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b>		DUE TO <b>170x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Four days</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Metastatic Cancer to the Lung.</b>		(b) DUE TO <b>Cancer of the Right Breast</b>		2 Months.							
(c) DUE TO <b>---</b>		3 1/2 Years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Pocomoke City</b>		(County) <b>Md.</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>July</b> , 1957, to <b>Nov. 15</b> , 1957, that I last saw the deceased alive on <b>Nov. 15</b> , 1957, and that death occurred at <b>220A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED							
ACTUAL SIGNATURE <b>Charles W. Trader, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>		22. MEDICAL CERTIFICATION							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Salem M.E. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Pocomoke City, Maryland</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Watson</b>		ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Anne White</b>					

DEPARTMENT OF HEALTH - CALIFORNIA

CERTIFICATE OF DEATH

NAME OF DEATH

DEATH

BUREAU Y. S.

NOV 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12516 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12507  
350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>M D</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				b. COUNTY <b>WORCESTER</b>			
c. LENGTH OF STAY IN 1b <b>81 yrs</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XI BERLIN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1 R.F.D.</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>BEAUCHAMP</b>	4. DATE OF DEATH	Month <b>NOV</b>	Day <b>14</b>	Year <b>1957</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 11, 1877</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>PITTSVILLE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEONARD BEAUCHAMP</b>		14. MOTHER'S MAIDEN NAME <b>NANCY CAREY</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>MR. AUBREY BEAUCHAMP, LEWES, DEL.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>973.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsons Disease</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shuts eye in car &amp; these connected to exhaust.</b>					
20c. TIME OF INJURY Hour <b>67</b> o. m. p.m.		Month, Day, Year <b>11/14/1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James A. Rabine</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/15/57</b>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-17-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>EVERGREEN</b>	22d. LOCATION (City, town, or county) <b>BERLIN</b>		(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna H. Burdage Berlin Md.</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>NOV 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred F. Hayward</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, removal.

WISCONSIN STATE GOVERNMENT OF HIGH-LEVEL-URANIUM-10  
MEDICAL EQUIPMENT & CLOTHING-OR-DEATH

BUREAU V. #

NOV 19 1957

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit Permit. Then please remove carbon paper. Form 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12517

CERTIFICATE OF DEATH

12598  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>		c. LENGTH OF STAY IN 1b X2 <b>Stockton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		e. STREET ADDRESS <b>R.F.D.</b>	
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>Bonneville</b>	Middle Last
4. DATE OF DEATH <b>Nov. 21 1957</b>		Month	Day
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>June 3, 1890</b>		9. AGE (In years lost birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR <b>Months</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>
11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		12. MOTHER'S MAIDEN NAME <b>Lizzie?</b>	
13. FATHER'S NAME <b>Edward Bonneville</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-12-1888</b>	17. INFORMANT <b>Annie Bonneville, New Church, Va.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		Address <b>Conanay Elementary School</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>extremosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
DUE TO (c)		7 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 20, 1957</b> to <b>Nov 21, 1957</b> , that I last saw the deceased alive on <b>Sept 20, 1957</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>O. E. Crichton</b> M.D. ADDRESS <b>Green Street, New Church, Va.</b> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 24, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Wardtown Cemetery</b>
22d. LOCATION (City, town, or county) <b>Pocomoke City, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar A. Parker</b>		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE <b>Elmer Cooper</b>

CERTIFICATE OF DEATH

299-1000

1957

BUREAU V. 2

NOV 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12518 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12509  
355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>WORCESTER</i>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DEL</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin Rd</i>	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MILLSBORO 46x-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <i>WILLIE</i>	Middle <i>Lee</i>	Last <i>BOWSER</i>	4. DATE OF DEATH <i>Nov. 17 1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 29, 1936</i>	9. AGE (in years last birthday) <i>21 yrs.</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hour <input type="checkbox"/> Min. <input type="checkbox"/>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>CHICKEN PLANT</i>	11. BIRTHPLACE (State or foreign country) <i>NEWARK MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>LEST Bowser</i>	14. MOTHER'S MAIDEN NAME <i>LURINA DEBERRY</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>219-32-3832</i>	17. INFORMANT <i>LEST Bowser NEWARK MD</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock due to Multiple Contusion, second</i>	
823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>&amp; Fractures to Fore skull, Compa</i>	DUE TO <i>pressure of chest &amp; Contusion to abdomen</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Passenger in car was struck off road &amp; struck a tree</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Month, Day, Year <i>6 Nov 11/17 1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Holiday 452-113 Berlin Rd &amp; Nonister Rd</i>	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>
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ACTUAL SIGNATURE <i>James A. Raber</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>11/17/57</i>
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/24/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>WITTMAMS</i>	22d. LOCATION (City, town, or county) (State) <i>WITTMAMS VA.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>James A. Bubby Berlin Rd</i>	ADDRESS <i>1111 10th St. NW Washington, D.C.</i>	24a. REC'D BY REGISTRAR <i>NOV 21 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Robert F. Hayward</i>
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WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF DEATH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
NOV 21 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12510

12519

## CERTIFICATE OF DEATH

Reg. Dist. No. 255

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>WORCESTER</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 OCEAN CITY</b>		d. STREET ADDRESS <b>1 PHILADELPHIA AVE</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>WILMER MELVIN CROPPER</b>		First	Middle	Last	4. DATE OF DEATH <b>Nov. 19 1957</b>	Month	Day	Year						
S. SEX <b>M</b>	6. COLOR OR RACE <b>WV</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 8, 1902</b>	9. AGE (In years lost birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRGD COAST GUARD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>V.S.C.G.</b>		11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13. FATHER'S NAME <b>WILLIAM A. CROPPER</b>		14. MOTHER'S MAIDEN NAME <b>H. MARY MELVILLY</b>		15. INFORMANT <b>MRS. ROBERT AKIN, OCEAN CITY, MD.</b>		Address								
16. SOCIAL SECURITY NO. <b>W 060 000 000</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF LIVER</b> DUE TO 156.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 months.</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>OCEAN CITY, MD</b>		(County)	(State)
21. I certify that I attended the deceased from <b>MARCh 1957</b> to <b>Nov 19, 1957</b> , that I last saw the deceased alive on <b>NOV 18, 1957</b> , and that death occurred at <b>3A M.</b> from the causes and on the date stated above.		ACTUAL SIGNATURE <b>FRANCIS JAMES TOWNSEND, JR.</b>		ADDRESS (Street, city or town, state) <b>OCEAN CITY, MD</b>		DATE SIGNED <b>NOV 20, 1957</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/22/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) <b>BERLIN</b>		(State) <b>MD</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna D. Burley Berlin Md</b>		ADDRESS <b>1122/57</b>		24a. REC'D BY REGISTRAR <b>NOV 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>F. Hayward</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then, please remove carbon paper, fill in item 3, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT OF HEALTH-EDUCATION-10

CERTIFICATE OF DEATH

ST. CLOUD  
HOSPITAL

25-11

DEATH CERTIFICATE

BUREAU V. 2

NOV 21 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12511

12520

## CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville		b. COUNTY Worcester				
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) ELIZABETH		First Middle DAVIDSON	4. DATE OF DEATH Nov. 26 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1876			
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home				
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John W. Latchum		14. MOTHER'S MAIDEN NAME Mary C. Hearn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. James Latchum			
		Address Bishop, Md. RFD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Sensibility</i> DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH 5-10 min						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dr. G. L. of Berlin, Md.	20f. (City or town) Berlin, Md.	(County) Anne Arundel Co.	(State) Md.
21. I certify that I attended the deceased from _____ on _____, 19_____, and that death occurred at _____ PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Selbyville, Del.		DATE SIGNED		
ACTUAL SIGNATURE <i>Earl B. M. Fadden</i>		PHYSICIAN'S NAME (Type) <i>Earl B. M. Fadden</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/57	22c. NAME OF CEMETERY OR CREMATORIAL I. O. O. F.	22d. LOCATION (City, town, or county) Bishopville, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter Phaleg Selbyville Del.</i>		ADDRESS		24a. REC'D BY REGISTRAR DEC 2 1957	24b. REGISTRAR'S SIGNATURE <i>Eilda Sergey</i>	

8 C 380-01728-01038-0 TRUSTEES STATE OF ILLINOIS

## BUREAU V. S.

DEC 2 1957

REGELVÉD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12521

## CERTIFICATE OF DEATH

12512351  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millwood</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millwood</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>xo Millwood</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Sidney</i>	Middle <i>J.</i>	Last <i>Davis</i>	4. DATE OF DEATH <i>Nov. 18 1957</i>	Month <i>Nov.</i>	Day <i>18</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 30 1875</i>	9. AGE (In years last birthday) <i>82 yrs 11 mos</i>	10. IF UNDER 1 YEAR - Months <i>0</i>	11. IF UNDER 24 HRS. - Days <i>0</i>	12. IF UNDER 24 HRS. - Hours <i>0</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gravitation</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Sacal</i>	11. BIRTHPLACE (State or foreign country) <i>Millwood Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>Millwood Md</i>
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13. FATHER'S NAME <i>William E. Davis</i>	14. MOTHER'S MAIDEN NAME <i>Settie Davis</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mrs. Clifford E. Davis</i>	Address <i>Millwood Md</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>481X</i>	RECENT OR PREVIOUS DISEASE <i>Chronic Emphysema</i>	INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Influenza</i>	DUE TO <i>Influenza</i>	5 days.
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month <i>Nov.</i>	Day <i>13</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Millwood Md</i>	20f. (City or town) <i>Baltimore Md</i>	(County) <i>Baltimore</i>	(State) <i>Md</i>
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21. I certify that I attended the deceased from <i>Nov. 13, 1957</i> to <i>Nov. 18, 1957</i> that I last saw the deceased alive on <i>Nov. 18, 1957</i> , and that death occurred at <i>Millwood Md</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Baltimore Md</i>	DATE SIGNED <i>Nov. 20, 1957</i>
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ACTUAL SIGNATURE <i>Clifford E. Schott</i>	PHYSICIAN'S NAME (Type) <i>Clifford E. Schott</i>	22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial Nov. 20, 1957</i>	22b. DATE THEREOF <i>Nov. 20, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bowen Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md</i>	(State) <i>Md</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay B. Dennis</i>	ADDRESS <i>Snow Hill Md</i>	24a. REC'D BY REGISTRAR <i>NOV 20 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Elwyn Cooper</i>
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MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF  
CERTIFICATE OF DEATH

BUREAU V. S

NOV 20 1957

REGELIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12522

## **CERTIFICATE OF DEATH**

12513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MD		b. COUNTY		WORCESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x2 BERLIN		d. STREET ADDRESS		1 R.F.D		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.					
M	W		MAR. 17, 1883		74 yrs.	Months Days	Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
RETIRED COAST GUARD		GOVERNMENT		BERLIN MD RFD		U.S.A						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address								
JOHN J. GIBBS SR.		SARAH ELIZABETH POWELL		MRS JOHN J. GIBBS BERLIN MD RE								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH						
YES	(If yes, give war or dates of service)			MRS JOHN J. GIBBS BERLIN MD								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		DUE TO										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage										
290.0												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO										
(b)		Cerebrovascular Disease										
DUE TO												
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
19												
21. I certify that I attended the deceased from April 1957, to Nov 4 - 1957, that I last saw the deceased alive on Mar 3 - 1957, and that death occurred at 11:54 A.M. from the causes and on the date stated above.												
ADDRESS (Street, city or town, state)												
ACTUAL SIGNATURE Chas R. Law M.D. DATE SIGNED 11-5-57												
PHYSICIAN'S NAME (Type)												
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)				
BURIAL		11/6/1957		EVERGREEN		BERLIN		MD				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
Anne A. Burboe Berlin MD				NOV 6 1957		F. Leland F. Haynes						

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Form 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **Forms 1 and 2** should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JULY 6 1957

RECEIVED

JULY 1957 EXAMINER:

13793.48

Reg. Dist. No

**○** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, and forward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**○ FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,

1. PLACE OF DEATH a. COUNTY		Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND		a. STATE MD b. COUNTY Worcester	
Ocean City		10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		5. Baltimore Ave		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
James				GRAHAM	Month Nov Day 27 Year 1957
5. SEX		Color or Race	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years last birthday)	
Male		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1902 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Nite Club Operator		Nite club		Snow Hill, North Carolina	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
John Speed		Mahalie James		Snow Hill, N.C.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		214-16-2544		Mahalie James	
PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
322.0		Acute congestive Heart Failure		instant	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Hypertension/Arterial P.H.P. (c) Acute alcoholism		59/1944	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		160.30.57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Burial		12/3/57		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Clinton T. Stewart		Salisbury Maryland		24b. REGISTRAR'S SIGNATURE	

RECEIVED  
DEC 10 1957

BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12523 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>		c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>IDA</b>	Middle <b>CALVERT</b>
4. DATE OF DEATH		Last <b>HASTINGS</b>	Month <b>November</b> Day <b>10</b> Year <b>1957</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>WV</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 3, 1862</b>
9. AGE (in years last birthday) <b>95 yrs.</b>	10. IF UNDER 1 YEAR Months <b>95</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>CALVERT Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CONNELLEE</b>		14. MOTHER'S MAIDEN NAME <b>PRICILLA JENKINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. EDGAR PAYNE</b>		Address <b>OCEAN CITY MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic degeneration myopathy &amp; anasarca 10 yrs</b>			
DUE TO <b>420.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Coronary arteriosclerosis &amp; arteriosclerosis</b> <b>several yrs 10 yrs</b>			
DUE TO (c) <b>Senility</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
MULTIPLE PETECHIAL, haemorrhage, due to friability, jaggedness			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Hermon A. Robbins</b>		DATE SIGNED <b>11/16/57</b>	
EXAMINER'S NAME (Type) <b>Hermon A. Robbins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>ST PAUL'S</b>		22d. LOCATION (City, town, or county) (State) <b>HUNTERSON MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna H. Burbridge Berlin Md</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>NOV 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Hayward</b>	

BUREAU A. S.

NOV 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12512 CERTIFICATE OF DEATH

12515

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>42</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>801 Clarke Avenue</b>		d. STREET ADDRESS <b>801 Clarke Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>SHELTON</b>		First <b>SAMUEL</b>	Middle <b>HINMAN</b>	Last <b>HINMAN</b>	4. DATE OF DEATH <b>November</b>	Month <b>13</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 1, 1912</b>		9. AGE (In years last birthday) <b>45</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chicken Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Asher Shelton Hinman</b>				14. MOTHER'S MAIDEN NAME <b>Melissa Mears</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>223-24-6901</b>		17. INFORMANT <b>Mrs Willve Hinman, Pocomoke City, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO <b>ACUTE MYOCARDIAL INFARCTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. p.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Pocomoke City</b>		(County) <b>WORCESTER</b> (State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>JAN 1</b> , 1956, to <b>Nov. 13</b> , 1957, that I last saw the deceased alive on <b>Nov. 13</b> , 1957, and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>C. STANFORD HAMILTON</b> M.D. PHYSICIAN'S NAME (Type) <b>C. STANFORD HAMILTON</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-15-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Nelson Cemetery</b>		22d. LOCATION (City, town, or county) <b>Rural Pocomoke City, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>		ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D. BY REGISTRAR <b>NOV 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Anne White</b>		

UNITED STATES GOVERNMENT - SECURITY INFORMATION

CERTIFICATE OF DATA

BUREAU V. S

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this form should be detached for use as the burial-transit permit. Then please remove carbon papers. Form 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12524

## CERTIFICATE OF DEATH

12516  
Reg. Dist. No. 224

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill, Maryland</i>		c. LENGTH OF STAY IN 1b <i>4 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Snow Hill Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill, Maryland</i>	
3. NAME OF DECEASED (Type or print) <i>Charles J. Mack Sr.</i>		4. DATE OF DEATH <i>November 14 1957</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 25 1899</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Joiner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Timber Mill</i>	
10c. BIRTHPLACE (State or foreign country) <i>Rocky Way Beach N.Y.</i>		11. AGE (In years from birthday) <i>68 yrs 14 mos</i>	
12. CITIZEN OF WHAT COUNTRY? <i>United States</i>		13. FATHER'S NAME <i>Otto Mack</i>	
14. MOTHER'S MAIDEN NAME <i>Cimilia Shillys</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>053-12-4211</i>		17. INFORMANT <i>William Mack</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>193X</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
DUE TO <i>HYPOSTATIC PNEUMONIA</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Left Parietal Astrocytoma</i>		20. DUE TO <i>6 to 8 months</i>	
DUE TO <i>Left Parietal Astrocytoma</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 15 1957</i> to <i>Nov 14 1957</i> , and that death occurred at <i>Snow Hill, Md.</i> alive on <i>Nov 1 1957</i> , and that death occurred at <i>Snow Hill, Md.</i> that I last saw the deceased		22. DATE OF DEATH <i>Nov 14 1957</i>	
ACTUAL SIGNATURE <i>Robert C. La Mar</i>		23. PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M.D.</i>	
24. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		25. DATE THEREOF <i>Nov 18 1957</i>	
26. NAME OF CEMETERY OR CREMATORIAL FACILITY <i>Long Island Cemetery</i>		27. LOCATION (City, town, or county) (State) <i>Long Island, N.Y.</i>	
28. FUNERAL DIRECTOR'S SIGNATURE <i>Elwyn Cooper</i>		29. ADDRESS <i>Elwyn Cooper</i>	
30. REC'D. BY REGISTRAR <i>Elwyn Cooper</i>		31. DATE <i>Nov 18 1957</i>	

## CERTIFICATE OF DEATH

REGISTRATION

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Form 1 and 2 should be filed with  
the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12525 CERTIFICATE OF DEATH

12517  
251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Warren</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>84 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>S. Lillie</i>	4. DATE OF DEATH Month <i>Nov.</i> Day <i>22</i> Year <i>1957</i>	Middle <i>A.</i>	5. SEX Female
6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>April 24 1873</i>	9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Snow Hill, MD</i>	12. CITIZEN OF WHAT COUNTRY? <i></i>
13. FATHER'S NAME <i>Stephen E. Mason</i>	14. MOTHER'S MAIDEN NAME <i>Elley M. Richardson</i>	Address <i>McMallie J. Mason Snow Hill, MD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>McMallie J. Mason</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <i>ACUTE PULMONARY EDEMA</i> DUE TO (c) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>1 hour</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>JUNE 15, 1957</i> , to <i>NOV. 22, 1957</i> , that I last saw the deceased alive on <i>NOV. 22, 1957</i> , and that death occurred at <i>9 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C. La Mar</i>	ADDRESS (Street, city or town, state) <i>104 Bay St Snow Hill, Md.</i>		
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M.D.</i>	DATE SIGNED <i>11-23-57</i>		
22. BURIAL, CREMATION, ETC. DATE THEREOF REMOVAL (Specify) <i>Nov. 25/57</i>	23. NAME OF CEMETERY OR CEMETARY <i>Episcopal Cemetery</i>	24a. LOCATION (City, town, or county) <i>Snow Hill, MD</i>	(State) <i></i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elley E. Dennis</i>	ADDRESS <i>Snow Hill, MD</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 25 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Elroy Cooper</i>

## C. CERTIFICATE OF DEATH

BUREAU V. 2  
RECEIVED  
NOV 25 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12518		
12513 CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY Worcester					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					12518		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City					c. LENGTH OF STAY IN 1b 42 years					b. COUNTY Worcester		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 440 Linden Avenue					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MAUDE					First C.		Middle MATTHEWS		4. DATE OF DEATH November		Month Day Year 11 19 57	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH February 28, 1894		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Edward Lawson					14. MOTHER'S MAIDEN NAME Bertha Sterling							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT Norman W. Matthews, Pocomoke City, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. p. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pocomoke City		(County)	(State)	
21. I certify that I attended the deceased from <u>October 13, 1954</u> to <u>Nov 13, 1957</u> , that I last saw the deceased alive on <u>Oct 13, 1957</u> , and that death occurred at <u>Pocomoke City, Md.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pocomoke City, Md.												
DATE SIGNED 12/12/57												
ACTUAL SIGNATURE N. E. Sartorius Sr.		PHYSICIAN'S NAME (Type) N. E. Sartorius Sr.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CEMETORY Baptist Cemetery					22d. LOCATION (City, town, or county) Pocomoke City, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sartorius		ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR Nov 13/1957 DATE		24b. REGISTRAR'S SIGNATURE Anne White						

CERTIFICATE OF DEATH

BUREAU V.

NOV 15, 1957

REGELIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12514 CERTIFICATE OF DEATH

12519  
350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>		c. LENGTH OF STAY IN 1b <b>27 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 Fourth Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>	
3. NAME OF DECEASED (Type or print) <b>GROVER</b>		First <b>CLEVELAND</b>	Middle <b>PIEPER</b>
4. DATE OF DEATH <b>November 30,</b>	Month <b>19 57</b>	Day <b>Year</b>	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veterinarian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Veterinary Medicine</b>	
11. BIRTHPLACE (State or foreign country) <b>Granite City, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Pieper</b>		14. MOTHER'S MAIDEN NAME <b>Mary Reif</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Evelyn Pieper, Pocomoke, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (d), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 yr</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<b>Congestive Heart Failure</b> <b>Hypertension</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/20</b> , 19 <b>51</b> , to <b>30 Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>30 Nov</b> , 19 <b>57</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Chincoteague, VA.</b>	
ACTUAL SIGNATURE <b>Henrik Shelley, M.D.</b>		DATE SIGNED <b>1957</b>	
PHYSICIAN'S NAME (Type) <b>Henrik Shelley, M. D.</b>		22d. LOCATION (City, town, or county) <b>Pocomoke, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Presbyterian Cemetery</b>		22d. LOCATION (City, town, or county) <b>VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Grisfield, Maryland</b>		ADDRESS	24a. REC'D BY REGISTRAR DATE <b>12/3/57</b>
			24b. REGISTRAR'S SIGNATURE <b>Anne E. White</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Fill in Form 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BUREAU V. S.

DEC 6 1957

## РЕГЕЛИЯ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12515 CERTIFICATE OF DEATH

12520  
250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		c. LENGTH OF STAY IN 1b RURAL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		e. STREET ADDRESS <b>R.F.D. #2 BX 23</b>				d. STREET ADDRESS <b>R.F.D. #2 BX 23</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Katherine</b>		First <b>Katherine</b>		Middle <b>Smith</b>		Last <b></b>		4. DATE OF DEATH <b>November 7</b>		Month <b>7</b>	Day <b>57</b>	Year
S. SEX <b>F.</b>	6. COLOR OR RACE <b>Ca.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1911</b>		9. AGE (In years last birthday) <b>45 yrs.</b>		IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Thomas Copes</b>				14. MOTHER'S MAIDEN NAME <b>Lizzie Logan</b>				Address <b>Elmer Smith, Pocomoke, Md.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>213-16-7592</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion of uterus</b> DUE TO <b>1748</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Wardstown</b>		(County) <b></b>		(State) <b></b>		
21. I certify that I attended the deceased from <b>Nov. 7</b> to <b>Nov. 7</b> , 1957, that I last saw the deceased alive on <b>7 Nov. 1957</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b></b>				
ACTUAL SIGNATURE <b>H. Dudley Jr.</b>								DATE SIGNED <b></b>				
PHYSICIAN'S NAME (Type) <b>Chamblee Jr.</b>		M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Wardstown</b>		22d. LOCATION (City, town, or county) <b>Pocomoke Md.</b>		(State) <b></b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton - New Church, Jr.</b>		ADDRESS <b></b>						24a. REC'D BY REGISTRAR <b>NOV 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John White</b>		

THE NATIONAL SECURITY AGENCY  
CERTIFICATE OF DECRYPTION

BUREAU V. S.  
NOV 19 1957  
RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**12526 CERTIFICATE OF DEATH**

12526  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Selbyville, Del.</b>		c. LENGTH OF STAY IN 1b <b>15Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/RURAL Selbyville, Del.</b>	
3. NAME OF DECEASED (Type or print) <b>MINNIE</b>		First <b>ANN</b>	Middle <b>L</b>
4. DATE OF DEATH <b>NOV. 26</b>		Month <b>Nov.</b>	Day <b>26</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 30, 1888</b>		9. AGE (In years (at birthday) yrs.) <b>89</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frank Savage</b>	
14. MOTHER'S MAIDEN NAME <b>Manie Fisher</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>William R. Tubbs</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>42a. 1 Coronary Thrombosis</b>		Address <b>Selbyville, Del. RFD</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
(b) <b>Coronary Artery Disease</b>		8 yrs	
DUE TO (c) <b>Sen. Atherosclerosis</b>		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 11/25/57</b> to <b>26 Nov 1957</b> , that I last saw the deceased alive on <b>11/25/57</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Bay St. Berlin, Md.</b>	
ACTUAL SIGNATURE <b>Herman A. Radin</b>		DATE SIGNED <b>11/26/57</b>	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>11/29/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Zion Church yard</b>	
22d. LOCATION (City, town, or county) <b>Bishopville, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Selbyville, Del.</b>		24a. REG'D BY REGISTRAR DATE <b>DEC 2 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Helen J. Hayward</b>	

## CERTIFICATE OF DEATH

RECEIVED  
DECEMBER 2 1957  
BUREAU V. S.

TO GENERAL DIRECTOR: After his certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12527 CERTIFICATE OF DEATH

12522 35F  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>		d. STREET ADDRESS <b>DIVISION ST</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>EVELYN</b>	Middle <b>ELLEN</b>	Last <b>WALLACE</b>	4. DATE OF DEATH <b>Nov. 18 1957</b>	Month <b>Nov.</b>	Day <b>18</b>	Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 21, 1883</b>	9. AGE (In years lost birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>SALISBURY MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN L. BAKER.</b>		14. MOTHER'S MAIDEN NAME <b>MARIA MIDDLETON</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. SCOTT WALLACE OCEAN CITY, MD.</b>		Address <b>200x Ocean City, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Cerebral vascular</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Cerebral vascular</b>		(c)				<b>4 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260x Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>OCEAN CITY, MD.</b>		(County) <b>WORCESTER</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from _____, 19 <sup>57</sup> to 19 <sup>57</sup> , that I last saw the deceased alive on _____, 19 <sup>57</sup> , and that death occurred at 10:10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>OCEAN CITY, MD.</b>							DATE SIGNED <b>20 Nov 57</b>
ACTUAL SIGNATURE <b>J. J. Thomas</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>J. J. Thomas</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/21/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna B. Bubye Berlin Md.</b>		ADDRESS <b>1121/57</b>		24a. REC'D BY REGISTRAR <b>NOV 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert F. Haywood</b>			

## CERTIFICATE OF DEATH

RECEIVED  
MAY 21 1957  
BUREAU V. A.